STATE OF NEW YORK
DEPARTMENT OF HEALTH

433 River Street, Suite 303 Troy, New York 12180-2299

Antonia C. Novello, M.D., M.P.H., Dr.P.H.
Commissioner

Dennis P. Whalen
Executive Deputy Commissioner

February 19, 2004

CERTIFIED MAIL - RETURN RECEIPT REQUESTED

Kevin C. Roe, Esq.
NYS Department of Health
ESP-Corning Tower-Room 2512
Albany, New York 12237

Thomas F. Gleason, Esq.
Gleason, Dunn, Walsh & O'Shea
102 Hackett Boulevard
Albany, New York 12209

Jose G. Posada, M.D.
1 Tallowwood Drive
Clifton Park, New York 12065

RE: In the Matter of Jose G. Posada, M.D.

Dear Parties:

Enclosed please find the **revised** Determination and Order (No. 04-37) of the Hearing Committee in the above referenced matter. This Determination and Order shall be deemed effective upon the receipt or seven (7) days after mailing by certified mail as per the provisions of §230, subdivision 10, paragraph (h) of the New York State Public Health Law.

As prescribed by the New York State Public Health Law §230, subdivision 10, paragraph (i), and §230-c subdivisions 1 through 5, (McKinney Supp. 1992), "the determination of a committee on professional medical conduct may be reviewed by the Administrative Review Board for professional medical conduct." Either the licensee or the Department may seek a review of a committee determination.

All notices of review must be served, by certified mail, upon the Administrative Review Board and the adverse party within fourteen (14) days of service and receipt of the enclosed Determination and Order.

The notice of review served on the Administrative Review Board should be forwarded to:

James F. Horan, Esq., Administrative Law Judge
New York State Department of Health
Bureau of Adjudication
Hedley Park Place
433 River Street, Fifth Floor
Troy, New York 12180

The parties shall have 30 days from the notice of appeal in which to file their briefs to the Administrative Review Board. Six copies of all papers must also be sent to the attention of Mr. Horan at the above address and one copy to the other party. The stipulated record in this matter shall consist of the official hearing transcript(s) and all documents in evidence.

Parties will be notified by mail of the Administrative Review Board's Determination and Order.

Sincerely,

Sean D. O'Brien/cah

Sean D. O'Brien, Director
Bureau of Adjudication

SDO:cah

Enclosure

STATE OF NEW YORK : DEPARTMENT OF HEALTH
STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

COPY

IN THE MATTER

OF

JOSE G. POSADA, M.D.

REVISED

DETERMINATION

AND

ORDER

BPMC# 04-37

KENDRICK A. SEARS, M.D., Chairperson, MARVIN HARTSTEIN, M.D., and **CLAUDIA GABRIEL,** duly designated members of the State Board for Professional Medical Conduct, appointed by the Commissioner of Health of the State of New York pursuant to Section 230(1) of the Public Health Law. They served as the Hearing Committee in this matter, pursuant to Sections 230(1)(e) and 230(12) of the Public Health Law. **SUSAN F. WEBER, Attorney at Law,** Administrative Law Judge, was the Administrative Officer for the Hearing Committee. The Department of Health was represented by **DONALD P. BERENS, JR., General Counsel, KEVIN C. ROE, Associate Counsel. THOMAS F. GLEASON, Attorney at Law, of Gleason, Dunn, Walsh, & O'Shea, represented JOSE G. POSADA, M.D.**

After consideration of the entire record, the Hearing Committee submits this Determination and Order.[1]

[1] Following issuance of the original Determination and Order, Respondent's counsel sought the Panel's reconsideration of paragraph 9, alleging "clear ... error" regarding the patient's post-operative condition. Petitioner responded that the paragraph was correct. The Panel reconsidered all the evidence in light of the issues Respondent raised and Petitioner's response. As a result, paragraph 9 has been rewritten to revise the list of post-operative conditions and to clarify that not all the listed conditions arose within 24 hours of surgery. It is noted that the original language was intended to convey that Respondent continued to follow this difficult patient.

STATEMENT OF THE CASE

This matter came to the Hearing Committee by Notice of Hearing and Statement of Charges dated July 24, 2003, which charged Jose G. Posada, M.D., ("Respondent") with eight specifications of professional misconduct involving the care and treatment of three patients from approximately December, 1997 through January, 2002. The specifications allege gross negligence, gross incompetence, negligence on more than one occasion, and incompetence on more than one occasion. The Statement of Charges is annexed hereto as Appendix 1.

The Hearing Committee sustains one specification of negligence on more than one occasion. Specifications of gross negligence, incompetence and gross incompetence are not sustained.

SUMMARY OF PROCEEDINGS

Notice of Hearing and Statement of Charges	July 24, 2003
Respondent's Answer	August 21, 2003
Pre-hearing Conference	September 16, 2003
Hearing Days	September 16, September 30, October 1, 2, and 16, 2003.
Place of Hearing	New York State Dept. of Health Hedley Building 5th Floor Hearing Room 433 River St., Troy, NY 12180
Post-Hearing Briefs Received	December 4, 2003
Deliberations	January 6, 2004
Petitioner Appeared by	Donald P. Berens, Jr. General Counsel NYS Department of Health By: Kevin C. Roe, Associate Counsel Corning Tower Room 2512 Empire State Plaza Albany, NY 12237

Respondent Appeared by	Gleason, Dunn, Walsh & O'Shea Thomas F. Gleason, Attorney at Law 102 Hackett Blvd. Albany, NY 12209

WITNESSES

For the Petitioner	Richard H. Feins, M.D., Expert Linda Tripoli, R.N. Lauren Visker, R.N.
For the Respondent	Jack Parillo, M.D. Ronald S. Karo. M.D. William Vacca, M.D. Jose G. Posada, M.D.

FINDINGS OF FACT

Having heard testimony and considered evidence presented by both the Department of Health and the Respondent, the Hearing Committee makes the following findings of fact. Conflicting evidence, if any, was considered and rejected in favor of the cited evidence. All Hearing Committee findings in this case were unanimous, unless otherwise stated. All findings of fact were established by at least a preponderance of the evidence. Numbers in parenthesis refer to transcript pages (T. 25, e.g.) or exhibit pages (Ex. 4, p.6, e.g.) that the Hearing Committee found persuasive in determining a particular finding.

Findings Regarding Patient A

1. Patient A was a 72-year-old white woman with a history of hypertension, bronchial asthma, gastroesophageal reflux disease, and hyperlipidemia. She was admitted to St. Mary's Hospital, Troy, New York, on August 26, 1999, for evaluation and treatment of high blood pressure and rapid atrial fibrillation. A cardiology consult was obtained and recommended insertion of a cardiac pacemaker. (Ex. 2A, pp.3, 8-10, 27-28.)

2. On August 28, 1999, Respondent inserted a dual-chamber cardiac pacemaker. Patient A was hypertensive throughout the procedure, with most systolic blood pressures above 220. Respondent's operative report, dictated at 3:05 p.m., immediately after the procedure, does not indicate any difficulty with insertion or refer to multiple insertion attempts. The right ventricular pacing wire was inserted first, without apparent difficulty. The right atrial wire required higher than usual electrical threshold to pace the atrium. Respondent stated in the operative report that he believed this would improve with time. Patient A left the operating room in satisfactory condition. (Ex. 2A, pp. 189-190.)
3. Shortly after admission the PACU (Post Anesthesia Care Unit), Patient A was noted to be hypotensive, have back pain and a pasty color, and be cold and clammy. An abrupt drop in systolic blood pressure was noted at 3:45 p.m., falling from 170-190 mmHg to a range of 80 to 110mmHg. Patient A was clinically in shock and was treated with vasopressor medication and fluids to elevate her blood pressure. An emergency chest x-ray showed new pleural effusion. A chest tube was inserted and blood was drained. Packed red blood cells and platelets were administered, together with intravenous solutions. Patient A required five simultaneous intravenous lines to provide sufficient hemodynamic support. An echocardiogram showed cardiac tamponade (blood in the pericardial sac). (Ex. 2A, pp. 187-188, T. 33-35)
4. Respondent attempted pericardiocentesis, insertion of a needle into the pericardial sac to remove fluid and thereby relieve pressure on the heart. This was not successful. An echocardiogram revealed a moderate to large pericardial effusion. Patient A was returned to the operating room where Respondent created a subxyphoid window to drain blood from the pericardium. (Ex. 2A, pp. 230-231; T. 35-36.)

5. After Respondent created the cardiac window, approximately 200 cc. of blood spurted from the pericardium. Respondent inspected the right ventricle visually and with his finger and found no evidence of a lead perforation. Due to the nature of the surgical field, Respondent had no access to the right atrium and it was not palpated for a perforation. No further bleeding was noted at that time. The patient was returned to the PACU in stable condition. (Ex. 2A, p.231).
6. Based upon the information available at the time, including blood in the pleural space, blood in the pericardium, and higher than usual threshold of the atrial lead, Respondent knew or should have known that the atrial lead had perforated the heart. Investigation and evaluation should have been undertaken to determine whether the tip of the atrial lead remained outside the heart. Fluoroscopy, CT scan, and/or an echocardiogram should have been performed immediately after the second surgery to obtain this information. (T. 36-41).
7. On August 29, 1999 and September 2, 1999 (the first and fourth post-operative days), interrogations of the pacemaker showed adequate functioning, within the limits of the testing performed. (Ex. 2A, pp. 323-325).
8. Following the second surgery, Patient A was transferred to the floor. Serial electrocardiograms (EKG's) and telemetry were performed and recorded (Ex. 2A, pp. 127-164). These records demonstrate that the atrial lead was not functioning properly to pace the heart. (Ex. 2A, pp.127-164; T. 42-44, 123, 149).
9. During the post-operative period of hospitalization and following treatment of the cardiac tamponade, Patient A developed agitation and delirium, anemia, fever, elevated white blood count with a shift to the left, coagulopathy, atelecasis, pneumothorax, and an increasingly

tender and distended abdomen. Abdominal films showed "significant ileus." (Ex. 2A, pp. 3-7, 17, 24, 30-31, 42-45, 56, 90 - 97, 113, 117.)

10. On September 8, 1999, 10 days post-operative, a CT scan of Patient A's chest was performed to evaluate possible pulmonary thromboembolic disease. This scan showed that the tip of the atrial lead was one-half to two centimeters outside the heart. It was close enough to be sensing but perhaps too far out to be pacing. The radiologist reading the scan did not note the position of the atrial lead in the report. (Ex. 2A, p. 126; Ex. 2E; T. 45-55, 111-113, 154)

11. Patient A was transferred from St. Mary's Hospital to the Eddy Cohoes Rehabilitation Center on September 9, 1999. On September 11, she returned to St. Mary's through the emergency room, with worsening congestive heart failure and severe gastrointestinal conditions unrelated to the pacemaker, which proved untreatable. Upon autopsy after the patient's death, the right atrial lead was found free in the right chest cavity, having perforated the right lateral aspect of the right atrium. (Ex. 2A, 2B, 2C, and 2D).

Discussion of Patient A

It is apparent, early in Patient A's post-operative care, that there was a problem with the pacemaker leads, and that the Respondent knew it. Clearly, the instrument had perforated the heart. Respondent returned Patient A to the operating room to relieve the cardiac tamponade by creating a cardiac window. Accumulated blood was evacuated. In an attempt to determine the source of the bleeding, he palpated and visualized the ventricle, which had not been penetrated, but he was unable to examine the atrium due to the limited surgical field. However, Respondent stopped there. He should have aggressively pursued the source of the bleeding. Another physician had ordered a CT scan to rule out a pulmonary embolism, and Respondent should have

obtained the results. Similarly, an x –ray, echocardiogram, or fluoroscopy would have been helpful in determining where the problem lay.

The State's expert, Richard H. Feins, is a board certified thoracic surgeon, head of general thoracic surgery at the University of Rochester and Strong Memorial Hospital, and has a clinical practice that constitutes approximately 70% of his time, with teaching and administration making up the other 30%. The Committee found Dr. Feins' testimony to be clear, direct, competent and credible. The Committee relied upon Dr. Feins' evaluation of the records and his expert opinions.

Respondent testified that he felt the risks of further surgery to correct the damage caused by the perforation was too great in relation to the benefits derived. He believed that the bleeding had stopped, and to go further to determine the cause could be harmful to the patient and provide no useful information. Despite this testimony, it is impossible to tell from the patient's record what Respondent was thinking, what treatment options he considered, what judgments he made, or the bases for those judgments. These need to be documented. There are fairly straightforward non-invasive methods of finding which possible source of the bleeding was the culprit. Regardless of Dr. Karo's testimony, which the Committee considered but did not find convincing, Dr. Feins and the Committee were easily able to identify the atrial lead outside the cardiac border on the CT scan.

The Committee found that the Respondent's response to this patient's situation was extremely careless. It was incumbent upon him to determine the source of the patient's bleeding, in order to evaluate the patient's condition and the various treatment options available and their attendant risks, and document his reasons for his choice of treatment or lack of treatment. Further, this patient's condition required that both ventricular and atrial pacing, which she did

not receive due to incorrect placement of the atrial lead. While there are circumstances, as Dr. Feins testified, where a surgeon would not reposition an atrial lead that was not properly functioning due to its position, the physician must evaluate and document the reasons for such a decision.

Findings Regarding Patient B

12. Patient B was an 81 year old white female admitted on December 31, 2001, to St.Clare's Hospital by William M.Vacca, M.D., from a nursing home for evaluation and treatment of refractory progressive peripheral edema. (Ex. 3, pp.25-30).

13. Dr. Vacca is board certified in cardiology and internal medicine, and has a cardiology practice in Schenectady. He is chief of medicine at St. Clare's Hospital. (T. 643-4)

14. At admission, Dr. Vacca performed and documented a complete and thorough history, physical examination, and treatment plan. He noted that the patient was a good historian, whose history was supplemented by her daughter and partial old medical records available for review. Dr. Vacca noted a history of valvular heart disease and coronary artery disease. Patient B was status post 2-vessel coronary artery bypass graft surgery and mitral valve replacement with a Hancock prosthesis, approximately five years before. Patient B had chronic atrial fibrillation. In September 2001, Patient B had syncope and fell. A subdural hematoma was surgically drained. Coumadin was then discontinued. Also noted was past history of hypothyroidism, depression, and gastrointestinal bleed. (Ex. 3, pp.25, 30)

15. History of the present illness included progressive lower extremity edema, worse when standing, over the preceding several weeks. Despite increasing doses of Lasix IM, there was no improvement and the patient was referred to the hospital. She denied paroxysmal nocturnal dyspnea or orthopnea, and reported loose bowels after meals. (Ex. 3, pp.25, 30)

16. Under physical examination, Dr. Vacca noted that Patient B appeared chronically ill but in no acute distress, with blood pressure of approximately 90/78. Neck vein distension and low volume carotids were noted. Cardiac rhythm was irregular with a grade II-III/IV cooing holosystolic murmur best heard at the lower left sternal border, with radiation to the apex. The abdomen was noteworthy for probable hepatomegaly and a right upper quadrant scar. 2+ peripheral edema was noted. (Ex. 3, pp.26, 30)

17. Dr. Vacca noted that the electrocardiogram revealed atrial fibrillation at approximately 102 beats per minute, right axis deviation, poor R wave progression, incomplete right bundle branch block, with no old tracings available. An echocardiogram from October 1, 2001, showed severe tricuspid regurgitation with estimated pulmonary systolic pressure of 70 mmHg. There was moderate mitral regurgitation on the prosthetic mitral valve, bilateral atrial enlargement, and preserved left ventricular systolic function with grossly normal aortic valve. (Ex. 3, pp.26, 30)

18. Dr. Vacca's impression was an 81-year-old white female whose problems included right-sided congestive heart failure, likely secondary to corpulmonale resulting from mitral regurgitation. He noted chronic diarrhea, etiology unclear. His recommendations and handwritten orders were: "Admit to telemetry bed, cautious increase in diuretics, hold ACE inhibitors and Aldactone given the potential for fixed cardiac output and preserved systolic function on last echocardiogram, and repeat echocardiogram. Further

recommendations pending clinical developments in response to above." (Ex. 3, pp. 14, 26-27, 30)

19. Surgery to implant a cardiac pacemaker was not indicated for Patient B, nor did the admitting physician plan such surgery. (Ex. 3, T. 165)

20. Later that afternoon, Dr. Vacca called Respondent to request a surgical consult for pacemaker insertion on another St. Clare's patient. Dr. Vacca mistakenly gave Respondent Patient B's name and room number as the patient who required a pacemaker. His normal practice was to describe why the patient needed a pacemaker. In this case, the actual intended pacemaker patient was an elderly woman with sick sinus syndrome, who required abdominal surgery. She could not be cleared for surgery because her irregular heart rhythm could not be controlled with medication alone. With a pacemaker, medication could be used to lower her heart rate, while the pacemaker would prevent the heart rate from dropping too low. Insertion of the pacemaker was urgent surgery. (T.647, 661-3)

21. At approximately 10:20 p.m. on December 31, 2001, Respondent telephoned St. Clare's Hospital and ordered that Patient B be given nothing by mouth after midnight, permission for surgical implantation of a pacemaker be obtained, and insertion of the pacemaker be scheduled for 9:00 a.m. the following morning. (Ex. 3 p.15)

22. Patient B's hospital record does not contain a pre-operative report from Respondent. His consultation report describes, not Patient B's condition, but rather the condition of the actual pacemaker patient as apparently described to him by Dr. Vacca: past mitral annulplasty, sick sinus syndrome, past supraventricular tachycardia and atrial fibrillation, slow heart rate on oral medication, and bowel obstruction. (Ex. 3, pp. 28-9; T. 164,177-9)

23. Before operating on a patient, it is the physician's responsibility to evaluate the patient to determine whether surgery is indicated. An adequate pre-operative evaluation would include review of records, the taking of a history from the patient, and a physical examination. A competent physician conducting an examination of Patient B would have concluded that she did not require insertion of a pacemaker. (T. 167, 170-1)

24. On January 1, 2002, at approximately 9:00a.m., Respondent surgically implanted a permanent pacemaker in Patient B. Shortly thereafter, Dr. Vacca saw Patient B wheeling on a gurney to her room and discovered that Respondent had inserted a pacemaker in Patient B in error. (T. 647, 668-9)

25. Dr. Vacca contacted Respondent who immediately returned Patient B to the operating room and explanted the pacer. (T. 647-9)

Discussion Regarding Patient B

William Vacca, Chief of Medicine, called in the Respondent to consult on Patient B at St. Clare's Hospital. Dr. Vacca and the Respondent had worked together many times, and Respondent regarded Dr. Vacca highly. Dr. Vacca testified that he identified Patient B as the cardiac patient requiring the consult, in error. Dr. Vacca described the other patient's symptoms and history and ascribed them to Patient B, whose room number he provided to Respondent.

The record is clear that Respondent operated on Patient B in reliance upon Dr. Vacca's evaluation of the other patient, and without performing a basic pre-operative evaluation on Patient B. Respondent's testimony that he reviewed Patient B's records, took a history, and performed a physical examination before operating are not credible. Had he reviewed her

records, taken a history and performed a physical examination, he would undoubtedly have caught Dr. Vacca's error, and the pacemaker implant would not have taken place. Dr. Vacca's mistake was compounded by Respondent's failure to adhere to appropriate medical standards and to perform his own adequate evaluation of the patient's need for a pacemaker.

It is true that there were some minor similarities in the cardiac conditions of these two elderly women. But the fact that Respondent's pre-operative note repeats Dr. Vacca's description of the other patient's condition, and the fact that Patient B did not require a pacemaker, belies the assertion that he did his own evaluation of Patient B before performing the surgery.

Both Dr. Vacca and Respondent testified about the steps subsequently taken at many levels to assure that such a series of mistakes could not be repeated at St. Clare's. However, the Committee notes with concern that none of the remedial procedures discussed would have prevented this situation. Only the surgeon's compliance with appropriate medical standards in adequately evaluating the patient's condition, regardless of the source of the consultation or the high regard in which the referring physician is held, can prevent an outcome such as happened here. The Committee found that Respondent failed to adequately evaluate Patient B prior to surgery and that he inserted the pacemaker without medical justification.

Findings of Fact for Patient C

26. Patient C is an 82-year-old woman admitted to St. Clare's Hospital on December 5, 1997, with complaints of coughing, dyspnea, stridorous breathing, and wheezing at night. A bronchoscopy on 12/4/97 showed hypertrophied tissue in the subpharyngeal area with collapse of the upper airway on inspiration. There was a major obstruction just below the

glottis produced by a pulsatile external compressing mass posteriorly. Consults with a gastroenterologist and with Respondent were obtained. (Ex. 4, pp. 50-52, 49-51)

27. A CT scan of the chest determined an upper airway obstruction oropharyngeal with no evidence of any mass effect or any airway compression or narrowing of the tracheal or bronchial tree. Respondent recommended a triple endoscopy to assess the airway and the oropharyngeal area under general anesthesia, and explained the risks and benefits to Patient C. (Ex. 4, p. 49; T. 865-869)

28. On December 9, 1997, Respondent operated to assess Patient C's airway difficulties. Intubation with an endotracheal tube was not successful, so a cricothyroidotomy was attempted. The cricothyroidotomy catheter was placed and jet ventilation commenced. Using a Mueller blade, Respondent looked in the oropharynx and found no tumors. The cords were normal, trachea was normal, and no tumors or strictures were noted. Respondent's operative note continues with a description of the esophagoscopy as normal. He notes that there was a venous engorgement in the mucosa and with no gross masses. During the procedure, Patient C's blood pressure dropped to 90/50 and her oxygen saturation dropped from 99% to 84%, where they remained. Respondent's note states that Patient C tolerated the procedure but was unable too be weaned from the respirator and was sent to the Intensive Care Unit[2] in critical condition at approximately 4:45 p.m. (Ex. 4, pp. 98-100)

29. At admission to the PACU at 4:45, attended by Respondent and Dr. Chow, the anesthesiologist, the still-intubated patient's blood pressure had dropped to 75/50. Dusky discoloration of the face and bilateral breath sounds were noted. The nurse taking her

[2] The Intensive Care Unit is also referred to in this record as the PACU, Post-Anesthesia Care Unit or the Patient After Care Unit.

vital signs noticed subcutaneous emphysema, and informed the Respondent. Patient C's oxygen saturation dropped from 96% to 83% and her blood pressure dropped to 55/35. Ephedrine was given at 4:55. Oxygen saturation remained in the 70-80% range until 6:45, despite the patient being ventilated with 100% oxygen (Ex. 4, pp.92-95)

30. At approximately 5:10, Respondent ordered a chest x-ray, in response to deteriorating blood pressure and bronchospasm. The x-ray, a supine portable film ("the first x-ray"), was taken at 5:15 and read by Respondent at 5:28 approximately. (Ex. 4 p.14;T. 895)

31. According to the radiologist's report, this x-ray was suggestive of bilateral pneumothoraces with extensive subcutaneous emphysema and pneumoperitoneum. (Ex. 4 p. 323) Neither Respondent nor pulmonologist Michael Gorla, Patient C's attending physician, whom Respondent had summoned, observed any pneumothoraces on the first x-ray during their care of Patient C (T. 902, 904, 907), although Dr. Feins testified that a right side pneumothorax was clear and a left side pneumothorax was suggested. (T.243)

32. Respondent ordered a second x-ray, which was done at approximately 6:25 p.m. It was upon reading this second x-ray that Respondent and Dr. Gorla identified bilateral pneumothoraces as the probable cause of Patient C's respiratory distress. At 6:45 p.m., Dr. Gorla inserted chest tubes to treat the bilateral pneumothoraces. (Ex. 4, p.92; T. 372, 909)

Discussion Regarding Patient C

The Committee found that Patient C's post-operative record, together with the Respondent's credible testimony, indicate that the Respondent was in attendance with the patient in the PACU, actively engaged in diagnosing and treating her respiratory distress. That this proved to be complicated and difficult to accomplish was unfortunate but not the result of negligence.

Dr. Feins identified a fairly pronounced right pneumothorax and a less-pronounced left pneumothorax from the first x-ray. Together with the clinical signs of respiratory distress and subcutaneous air, at least a unilateral pneumothorax would have been the likely cause of Patient C's respiratory distress, he testified. (T 190) The radiologist also identified pneumothoraces on the first x-ray (Ex. 4, p.323), but it is not clear when his or her impression was conveyed to the Respondent.

However, neither the Respondent nor Dr. Gorla, a pulmonary specialist and critical care physician, was able to identify pneumothoraces from the first x-ray and clinical signs. Dr. Parillo and Dr. Karo, witnesses for the Respondent, testified that the first x-ray was difficult to read and did not definitively show a pneumothorax. To resolve the issue, a second x-ray was ordered. It was not until reading the second x-ray that Respondent and Dr. Gorla determined that bilateral pneumothoraces were present and inserted chest tubes at approximately 6:38 p.m. While the State's and Respondent's experts disagreed about whether the first x-ray provided sufficient information upon which to diagnosis pneumothoraces, the Committee found that such delay as did result was not beyond the reasonable, under all the medical circumstances. The Committee also found that Respondent did not abandon the patient, but rather stayed with the problem to resolution.

The Committee rejected the State's contention that Respondent should have inserted the chest tubes. Dr. Gorla, as the patient's attending, as well as a pulmonologist and critical care physician, was as appropriate as Respondent to perform the procedure.

The Committee worked to resolve Nurse Visker's credible testimony about Respondent's seeming callous disregard for a patient in extreme distress with the documentary evidence and testimony of the Respondent. Clearly, Nurse Visker felt a lack of decisiveness, guidance and direction on Respondent's part. Her testimony is at odds with the patient's record, which establishes Respondent's involvement – ordering medication and tests - throughout Patient C's time in the PACU. Respondent's lack of direction to staff on Patient C's treatment prior to the second x-ray resulted from the fact that there was no diagnosis, and therefore no guidance on treating this very ill woman. Naturally, this delay would have been difficult for caring PACU staff to handle. In all probability, discussion of the issues with staff as they unfolded could have made the situation more tolerable.

In conclusion, the Committee determined that the Respondent was unwilling to act on clear secondary signs of pneumothorax, but that this was not unreasonable. He did determine, in a timely manner, that an airway leak was causing Patient C's respiratory distress in the PACU. Further, the Committee found that it was not negligence that the Respondent, himself, did not insert the bilateral chest tubes to treat the condition.

VOTE OF THE COMMITTEE

The Committee votes unanimously as follows:

1. The first through third specifications of gross negligence are **NOT SUSTAINED.**
2. The fourth through sixth specifications of gross incompetence are **NOT SUSTAINED.**
3. The seventh specification of negligence on more than one occasion is **SUSTAINED,** based upon the allegations in paragraphs A and A1, and B, B1 and B2.
4. The eighth specification of incompetence on more than one occasion is **NOT SUSTAINED.**

PENALTY

The Committee found a common thread running through the three cases. That thread is the Respondent's apparent failure to adequately evaluate each patient's condition and to document his evaluation and the reasoning behind it. In Patient A, affirmatively assuming responsibility for the source of the bleeding and documenting his independent evaluation was required. In Patient B, performing the most basic independent evaluation would have prevented the error.

It was evident from the evidence presented that the Respondent is a skilled and generally conscientious practitioner. His shortcomings in the cases before this Committee stem from failing to exercise the judgment he clearly possesses and to share, through documentation and discussion with colleagues on staff, his diagnostic processes. Respondent is not a technician; he is a skilled surgeon whose primary responsibility is to his patients.

The Committee determined that the seriousness of these cases requires that Respondent's license to practice medicine be suspended for a period of two years from the date of this Order, and that such suspension be stayed, to become a two-year period of probation. During the probationary period, a board certified thoracic surgeon shall monitor Respondent's practice. The monitor shall assure that Respondent's evaluations clearly document the patients' conditions, care and treatment. The monitor shall bring any shortcomings to the attention of the Respondent and the Department of Health, OPMC.

ORDER

Based upon the foregoing, it is hereby ORDERED THAT:

1. Respondent's license to practice medicine in the State of New York is **SUSPENDED for two years from the date of this ORDER;**
2. The suspension is **STAYED and Respondent shall be on PROBATION for the two-year period;**
3. This **ORDER** shall be effective immediately upon service upon Respondent.

DATED: Syracuse, New York
February 18, 2004

KENDRICK A. SEARS, M.D.
Chairman

MARVIN HARTSTEIN, M.D.
CLAUDIA GABRIEL

TERMS OF PROBATION

1. Respondent shall submit written notification to the New York State Department of Health addressed to the Director, Office of Professional Medical Conduct (OPMC), Hedley Park Place, 433 River St., Troy, New York 12180-2299. The notice is to include: a full description of any employment and practice, professional and residential addresses and telephone numbers within or without New York State, and any and all investigations, charges, convictions, or disciplinary actions by any local, state or federal agency, institution, or facility, within thirty days of each such action.
2. Respondent shall fully cooperate with and respond in a timely manner to requests from OPMC to provide written periodic verification of Respondent's compliance with the terms of this Order. Respondent shall personally meet with a person designated by the Director of OPMC, as requested by the Director.
3. The period of probation shall be tolled during periods in which the Respondent is not engaged in the active practice of medicine in New York State. Respondent shall notify the Director of OPMC in writing if Respondent is not currently engaged in or intends to leave the active practice of medicine in New York State for a period of thirty (30) consecutive days or more. Respondent shall then notify the Director again prior to any change in that status. The period of probation shall resume and any terms of probation that were not fulfilled shall be fulfilled upon the Respondent's return to practice in New York State.
4. The Director of OPMC may review respondent's professional performance. This review may include, but shall not be limited to, a review of office records, patient records, and/or hospital charts, interviews with or periodic visits with the Respondent and his staff at practice locations or OPMC offices.
5. Respondent shall maintain legible and complete medical records that accurately reflect the evaluation and treatment of patients. The medical records shall contain all information required by State rules and regulations regarding controlled substances.
6. Within thirty (30) days of the effective date of the Order, Respondent shall practice medicine during the two-year probationary period only when monitored by a licensed physician, board certified in thoracic surgery, proposed by the Respondent and subject to the written approval of the Director of OPMC.

A. Respondent shall make available to the monitor any and all records or access to the practice requested by the monitor, including on-site observation. The practice monitor shall visit Respondent's medical practice on a random unannounced basis at least monthly and shall examine a selection of records maintained by the Respondent, including patient records, prescribing information and office records. The review will determine whether the Respondent's evaluation of patient conditions, differential diagnoses, treatment options, choices and the reasons for such choices are adequately explicated and documented, in accordance with generally accepted standards of professional medical care. Any perceived deviation from accepted standards of medical care or refusal to cooperate with the monitor should be reported within 24 hours to OPMC.

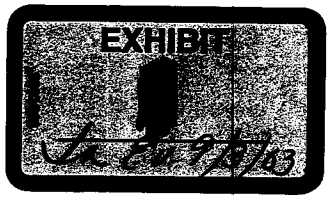
B. Respondent shall be solely responsible for all expenses associated with monitoring, including fees, if any, to the monitoring physician.

C. Respondent shall cause the practice monitor to report quarterly, in writing, to the Director of OPMC.

D. Respondent shall maintain medical malpractice insurance coverage with limits no less than $2 million per occurrence and $6 million per policy year, in accordance with Section 230(18)(b) of the Public Health Law. Proof of coverage shall be submitted to the Director of OPMC prior to Respondent's practice after the effective date of this Order.

7. Respondent shall comply with all terms, conditions, restrictions, limitations, and penalties to which he is subject pursuant to the Order, and shall assume and bear all costs related to compliance. Upon receipt of evidence of non-compliance with, or any violation of these terms, the Director of OPMC and/or the Board of Professional Medical Conduct may initiate a violation of probation proceeding and/or any other such proceeding against Respondent as may be authorized pursuant to law.

APPENDIX I



STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	NOTICE
OF	:	OF
JOSE G. POSADA, M.D.	:	HEARING

----------X

TO: JOSE G. POSADA, M.D.

PLEASE TAKE NOTICE:

A hearing will be held pursuant to the provisions of N.Y. Pub. Health Law Section 230 and N.Y. State Admin. Proc. Act Sections 301-307 and 401. The hearing will be conducted before a committee on professional conduct of the State Board for Professional Medical Conduct on the 16TH day of September, 2003,at 10:00 in the forenoon of that day at the 5th Floor Conference Room, Hedley Park Place, 433 River Street, Troy, New York and at such other adjourned dates, times and places as the committee may direct.

At the hearing, evidence will be received concerning the allegations set forth in the Statement of Charges, which is attached. A stenographic record of the hearing will be made and the witnesses at the hearing will be sworn and examined. You shall appear in person at the hearing and may be represented by counsel. You have the right to produce witnesses and evidence on your behalf, to issue or have subpoenas issued on your behalf in order to require the production of witnesses and documents and you may cross-examine witnesses and examine evidence produced against you. A summary of the Department of Health Hearing Rules is enclosed.

The hearing will proceed whether or not you appear at the hearing. Please note that requests for adjournments must be made in writing and by telephone to the Bureau of Adjudication, Hedley Park Place, 5th Floor, 433 River Street, Troy, New York 12180, (518-402-0748), upon notice to the attorney for the Department of Health whose name appears below, and at least five days prior to the scheduled hearing date. Adjournment requests are not routinely granted as scheduled dates are considered dates certain. Claims of court engagement will require detailed Affidavits of Actual Engagement. Claims of illness will require medical documentation.

Pursuant to the provisions of N.Y. Pub. Health Law Section 230(10)(c) you shall file a written answer to each of the Charges and Allegations in the Statement of Charges no later than ten days prior to the date of the hearing. Any Charge and Allegation not so answered shall be deemed admitted. You may wish to seek the advice of counsel prior to filing such answer. The answer shall be filed with the Bureau of Adjudication, at the address indicated above, and a copy shall be forwarded to the attorney for the Department of Health whose name appears below. Pursuant to Section 301(5) of the State Administrative Procedure Act, the Department, upon reasonable notice, will provide at no charge a qualified interpreter of the deaf to interpret the proceedings to, and the testimony of, any deaf person.

At the conclusion of the hearing, the committee shall make findings of fact, conclusions concerning the charges sustained or dismissed, and, in the event any of the charges are sustained, a determination of the penalty to be imposed or appropriate action to be taken. Such determination may be reviewed by the administrative review board for professional medical conduct.

THESE PROCEEDINGS MAY RESULT IN A DETERMINATION THAT YOUR LICENSE TO PRACTICE MEDICINE IN NEW YORK STATE BE REVOKED OR SUSPENDED, AND/OR THAT YOU BE FINED OR SUBJECT TO THE OTHER SANCTIONS SET OUT IN NEW YORK PUBLIC HEALTH LAW SECTION 230-a. YOU ARE URGED TO OBTAIN AN ATTORNEY TO REPRESENT YOU IN THIS MATTER.

DATED: Albany, New York
July 24, 2003

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel

Inquiries should be directed to:

Kevin C. Roe
Associate Counsel
Division of Legal Affairs
Bureau of Professional
Medical Conduct
2512 Corning Tower
Albany, New York 12237-0032
(518) 473-4282

STATE OF NEW YORK : DEPARTMENT OF HEALTH

STATE BOARD FOR PROFESSIONAL MEDICAL CONDUCT

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IN THE MATTER	:	STATEMENT
OF	:	OF
JOSE G. POSADA, M.D.	:	CHARGES

----------X

JOSE G. POSADA, M.D., the Respondent, was authorized to practice medicine in New York State on June 10, 1983 by the issuance of license number 154375 by the New York State Education Department.

FACTUAL ALLEGATIONS

A. Respondent treated Patient A (Patients are identified in the attached appendix.) from August 26, 1999, to September 12, 1999, at St. Mary's Hospital, Troy, NY. Respondent's care and treatment of Patient A failed to meet accepted standards of medical care in that:

1. Respondent failed to adequately evaluate Patient A after surgery.
2. Respondent failed to recognize that the atrial lead had perforated the heart in a timely manner.

B. Respondent treated Patient B from December 31, 2001, to January 10, 2002, at St. Clare's Hospital, Schenectady, NY. Respondent's care and treatment of Patient B failed to meet accepted standards of medical care in that:

1. Respondent failed to adequate evaluate Patient B before surgery.
2. Respondent inserted a pacemaker without medical justification.

C. Respondent treated Patient C from December 6, 1997, to December 15, 1997, at St. Clare's Hospital, Schenectady, NY. Respondent's care and treatment of Patient C failed to meet accepted standards of medical care in that:

1. Respondent failed to recognize that an airway leak was causing respiratory distress in the recovery room.
2. Respondent failed to insert bilateral chest tubes to treat Patient C's respiratory distress.

SPECIFICATIONS

FIRST THROUGH THIRD SPECIFICATIONS

GROSS NEGLIGENCE

Respondent is charged with gross negligence in violation of New York Education Law §6530(4), in that Petitioner charges:

1. The facts in Paragraphs A and A.1,and/or A.2.
2. The facts in Paragraphs B and B.1 and/or B.2.
3. The facts in Paragraphs C and C.1 and/or C.2.

FOURTH THROUGH SIXTH SPECIFICATIONS

GROSS INCOMPETENCE

Respondent is charged with gross incompetence in violation of New York Education Law §6530(6), in that Petitioner charges:

4. The facts in Paragraphs A and A.1,and/or A.2.
5. The facts in Paragraphs B and B.1 and/or B.2.
6. The facts in Paragraphs C and C.1 and/or C.2.

SEVENTH SPECIFICATION

NEGLIGENCE ON MORE THAN ONE OCCASION

Respondent is charged with negligence on more than one

occasion in violation of New York Education Law §6530(3), in that Petitioner charges two or more of the following:

7. The facts in Paragraphs A and A.1, A.2; B and B.1, B.2; and/or C and C.1, C.2.

EIGHTH SPECIFICATION

INCOMPETENCE ON MORE THAN ONE OCCASION

Respondent is charged with incompetence on more than one occasion in violation of New York Education Law §6530(5), in that Petitioner charges two or more of the following:

8. The facts in Paragraphs A and A.1, A.2, B and B.1, B.2; and/or C and C.1, C.2.

DATED: July 24, 2003
Albany, New York

Peter D. Van Buren
PETER D. VAN BUREN
Deputy Counsel
Bureau of Professional
Medical Conduct